NHS National Services Scotland

Duty of Candour Annual Report April 2020 to March 2021

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Introduction

All health and social care services in Scotland have an organisational duty of candour. This is a legal requirement, which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future. The procedure to be followed is set out in the Duty of Candour Procedure (Scotland) Regulations 2018.

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This report describes how we have operated the organisational duty of candour during the time between 1 April 2020 and 31 March 2021.

About NHS National Services Scotland

NHS National Services Scotland (NSS) is a national NHS Board operating across NHSScotland. We provide invaluable support and advice. This is a role which encompasses the wider public sector.

NSS supports the delivery of safe, effective and efficient health and social care throughout Scotland. We offer shared services on a national scale using best-in-class systems and standards. Our aim is to help our customers save money and free up resources so they can be re-invested into essential services. We also provide consultancy and support to help public bodies join up health and social care.

By connecting with partners and stakeholders in other public bodies, we can use our national position to ensure our services, solutions and programmes of work are aligned to, coordinated with, and enable regional and local activities.

NSS is made up of five strategic business units (SBU):

- Central Legal Office
- Digital and Security
- Practitioner and Counter Fraud Services
- Procurement, Commissioning and Facilities
- Scottish National Blood Transfusion Service

Four supporting business units and corporate directorates:

- Clinical
- Finance
- Human Resources and Workforce Development
- Strategy, Performance and Service Transformation

Number and nature of duty of candour incidents

In the last year, how many adverse events did the duty of candour apply?

NSS provides few services which are patient facing, outside of the Scottish National Blood Transfusion Service (SNBTS), and is usually in the role of a support organisation or in a sharing responsibility for delivery of services which are not necessarily frontline, for example Abdominal Aortic Aneurysm, Breast, Bowel, and Newborn Screening Programmes. NSS also provides substantial Digital support services. Due to the diverse nature of our services, we therefore look carefully at all adverse events in order to determine if the principles of duty of candour apply.

Between 1 April 2020 and 31 March 2021, three clinical adverse events were reviewed and confirmed as organisational duty of candour i.e. unintended or unexpected incident that resulted in death or harm as defined in the Act, and did not relate directly to the natural course of someone's illness or underlying condition.

NHS National Services Scotland identified these events through our adverse event management process. All adverse events are subject to a level of review, which includes a wider range of outcomes than those defined in the duty of candour legislation. This means that through the adverse event review process we may identify events that did not result in significant harm but had the potential to do so, and require a higher level of review.

Table 1: Nature of unexpected or unintended incident where duty of candour applies

Nature of unexpected or unintended incident where duty of candour applies	Number
A person died	
A person suffered permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	
Harm which is not severe harm but results or could have resulted in:	
An increase in the person's treatment	1
Changes to the structure of the person's body	
The shortening of the life expectancy of the person	
An impairment of the sensory, motor or intellectual functions of the person which has lasted, or is likely to last, for a continuous period of at least 28 days	1
The person experiencing pain or psychological harm which has been, or is likely to be, experienced by the person for a continuous period of at least 28 days.	1
The person required treatment by a registered health professional in order to prevent:	
The person dying	
An injury to the person which, if left untreated, would lead to one or more of the outcomes mentioned above.	

To what extent did NHS National Services Scotland carry out the duty of candour procedure?

A review was carried out for each event to understand what happened, what went wrong and what learning can be taken forward for the future. Each person affected received a formal letter of apology. In one case, the person affected did not wish any further follow up, one did not respond to correspondence and one met with an SNBTS clinician and received a copy of the investigation report. Two similar events triggered the organisational duty of candour procedure within SNBTS donor services. These events were followed up by SNBTS donor medical team, GP and/or specialist hospital services.

Information about our policies and procedures

In NSS, all adverse events and near misses are reported on Q-Pulse (with the exception of clinical adverse events in SNBTS) in line with the NSS Adverse Event Management Policy.

SNBTS report on an SNBTS specific version of Q-Pulse to meet their regulatory and legal requirements Clinical adverse events. This includes those which trigger the organisational duty of candour procedure, being identified on the system. SNBTS is working towards a more formalised procedure for defining when a donor event should trigger duty of candour.

NSS's adverse event management procedure is detailed within the NSS Adverse Event Management Policy whereby all adverse events are reviewed to understand what happened and how we might learn from, and improve the care and services we provide in the future. Consideration as whether the organisational duty of candour may apply is part of this procedure. The level of event review depends on the severity of the adverse event as well as the potential for learning. Recommendations are made, and local management teams develop improvement plans to meet these recommendations. In NSS, monitoring of adverse event reporting takes place via the information governance and clinical governance frameworks.

All staff must complete a mandatory information governance e-learning module, which includes how to identify and report an adverse event. Additional training is available on request for staff involved in reviewing adverse events on Q-Pulse, so that they understand when it applies and how to trigger the duty. In addition, SNBTS staff must receive training in Q-Pulse before they can access the system due to the strict legal requirements. During 2020, The Associate Director for Nursing, Clinical Governance and Quality Improvement began a planned roll out of bespoke duty of candour training with SNBTS staff. The national duty of candour e-learning module is available to all staff and it is a mandatory requirement for all registered healthcare professionals contracted to NSS to complete.

What processes are in place to identify and report unexpected or unintended incidents that may require activation of the duty of candour procedure?

The NSS Adverse Event Management Policy sets out the stages by which adverse events are reported, reviewed and managed, including consideration of duty of candour. The policy is aligned to the Healthcare Improvement Scotland National Adverse Event Framework. SNBTS have additional documentation relating to incident management in line with their legal requirements. In January 2021, a standard operating procedure was published for SNBTS staff setting out the formal and planned approach to identifying, reporting and managing duty of candour events. In addition, it included the escalation procedures to the NSS Medical Director via our Associate Director for Nursing, Clinical Governance and Quality Improvement within 72 hours of discovery.

Each relevant SBU has a clinical governance or senior management team meeting on a monthly basis where adverse events, including duty of candour, are discussed.

All duty of candour events are subject to a lesson learned approach and any learning identified is disseminated to staff, where appropriate. This helps to facilitate awareness and learning.

What criteria do you use to assess whether the duty of candour procedure should be activated?

In addition to our NSS Adverse Event Management Policy and SNBTS duty of candour standing operating procedure, we refer to the duty of candour guidance and FAQs by Scottish Government. When a possible duty of candour event is identified, there is discussion between clinicians and nominated duty of candour leads and partner agencies, where appropriate. Due to the complexity of our services, such as screening programmes, we must always consider duty of candour in its widest sense to include Public Health.

What support is available to staff who are involved in unintended or unexpected incidents resulting or could result in harm or death?

NSS has a commitment to all staff who are involved in an adverse event to ensure that they are offered support at a time and in a way which meets their needs. Staff involved in an adverse event may be physically and / or psychologically affected by what has happened. Line managers have a responsibility to check in with their staff and help to identify appropriate support for individuals and teams. This may include:

- protected time for a staff member in order to prepare information as part of an adverse event / duty of candour review
- referral to occupational health or advice around counselling services
- contact with their staff side representatives

What support is available to relevant persons who are affected by unintended or unexpected incidents resulting or could result in harm or death?

NSS will provide information and support to donors, patients, participants or families if they are affected by an adverse event where the organisational duty of candour is applied. Compassion and understanding should be demonstrated at all times and arrangements made for regular contact to keep people involved and informed. This will include:

- acknowledgement of the possible distress that the adverse event has caused
- a factual explanation of what has happened (as much as is known at the time), including a formal apology
- a clear statement of what is going to happen next as part of the duty of candour procedure
- any action which can be taken in the interim to resolve the adverse event
- a named contact

What changes, learning and/or improvements to services and patient outcomes can you identify as a result of activating the duty of candour procedure and the required reviews that have taken place?

As a result of activating the duty of candour procedure, we have:

- updated a standing operating procedure to improve our practice including recording of donor symptoms at time of donation
- established a Short Life Working Group to look at improving guidance for both staff and donors prior to donation, during the donor session and for post-donation care. The comments and feedback provided by the person at their meeting with clinical staff has been given due consideration
- a new procedure for reviewing certain complications of blood donation at an earlier stage is under development
- updated a standing operating procedure whereby a Traceline report will be printed and checked by a senior Bio Medical Scientist before results are sent to SCI Store

What improvements/ changes, if any, have been made to the approach to considering and implementing the duty of candour process itself, as a result of activating the procedure?

We have made a number of changes following review of the duty of candour events that we wish to highlight.

- Revised Clinical Governance and Quality Improvement Framework action plan with specific themes related to Adverse Event Management and duty of candour.
- Duty of candour standing operating procedure developed and implemented by SNBTS where our patient facing services are hosted.
- Review of Adverse Event Management Policy to include a more detailed procedure and escalation procedures.
- Bespoke duty of candour training programme for staff has commenced within SNBTS. Further sessions to include other SBUs are planned.

Covid-19 Pandemic

Setting the context

What processes were put in place to manage the impact of Covid-19 when activating the duty of candour procedure?

NSS are confident that the processes already in place were adequate to manage the very small number of duty of candour events in NSS. The development of the SNBTS standing operating procedure provided further assurance that such events could be managed.

Did the timeframe in which it took to review cases increase due to the ongoing pressures of dealing with Covid-19? If so, by how much?

COVID-19 did not affect the response time for any duty of candour events.

How many or what percentage of the times when the duty of candour procedure was activated this year have been directly attributable to Covid-19?

No adverse events where the organisational duty of candour was activated were directly attributable to Covid-19.

Practical Actions Taken

How has involving the relevant person been impacted by Covid-19? For example, involving relevant persons in review meetings and continuing communication.

Meetings with those affected by the duty of candour events were held over Microsoft Teams or by telephone rather than face-to-face.

In light of the Covid-19 pandemic, what adjustments have you made to continue to involve relevant persons as required by the duty of candour procedure?

Meetings will be held by telephone or online until Covid-19 restrictions allow face-to-face meetings.

The duty of candour procedure provisions reflect the Scottish Government's commitment to place people at the heart of health and social care services in Scotland. In light of this and the Covid-19 pandemic, how did you ensure a person centred approach was maintained when the decision was made to activate the duty of candour procedure?

An open, transparent and person centred approach has been maintained for all three events which activated the duty of candour procedure. We are confident that our processes and procedures reflected this approach.

Learning for the future

Responding to the Covid-19 pandemic will have meant changes to NHS National Services Scotland's policies and processes, including activating the duty of candour procedure for unintended or unexpected incidents resulting or could result in harm or death.

Duty of Candour Procedure

What changes, if any, to the way you consider and implement the duty of candour procedure will you continue with as the Covid-19 pandemic continues?

The improvements made in NSS to how we consider and implement organisational duty of candour were made as part of our Clinical Governance and Quality Improvements Framework action plan.

What difficulties have you encountered when reviewing unintended or unexpected incidents due to Covid-19? What learning can be taken away from these particular difficulties?

Covid-19 did not encounter difficulties when reviewing of any events due to Covid-19.

Provision of Healthcare Services

Has there been specific learning from activating the duty of candour procedure to unintended or unexpected incidents which have resulted in or could have resulted in harm and death which are directly linked to the Covid-19 response? If so, what has this learning been?

No adverse events where the organisational duty of candour was activated were directly linked to the Covid-19 response.

What other learning have you been able to identify as a result of applying the duty of candour procedure?

Any learning identified as a result of applying the duty of candour procedure has been in line with our current procedures and not related to Covid-19 or its response.

Additional Information

Please provide any further information you think might be important or relevant. For example, ways in which discussion, decision-making and reviews linked with the duty of candour procedure have supported continuous improvements in delivering safe, effective and person-centred care?

The discussion and decision-making forum around duty of candour has matured during the year. Potential events are considered at an earlier stage by a wider group of clinicians with a more rounded and informed approach to duty of candour being applied. In the NSS Clinical Governance and Quality Improvement Framework action plan for the coming year we plan to move our approach further on how we approach duty of candour in a national and population context.

Other information

This report is disseminated via the clinical governance framework for internal information prior to final approval by the Board. As required, we have submitted this report to Scottish Ministers and we have placed it on our website.

If you would like more information about this report, please contact us using these details:

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